Health Care
Special Report

Vital Signs of Critical Access Hospitals

Analysts
Tommy Chan
+1 212 908-0514
tommy.chan@fitchratings.com

Michael Borgani
+1 415 732-5620
michael.borgani@fitchratings.com

Garey Fuqua
+1 212 908-0684
garey.fuqua@fitchratings.com

Jim LeBuhn
+1 312 368-2059
james.lebuhn@fitchratings.com

Jim Mitchell
+1 813 222-1395
james.mitchell@fitchratings.com

Frederic J. Martucci
+1 212 908-0554
frederic.martucci@fitchratings.com

Marcelo L. Olarte
+1 212 908-0508
marcelo.olarte@fitchratings.com

Carolyn Tain
+1 212 908-0259
carolyn.tain@fitchratings.com

John E. Wells
+1 212 908-0674
john.wells@fitchratings.com

Summary

As many small rural community hospitals have struggled to cope with rising health care costs outpacing patient reimbursement, the critical access hospital (CAH) program has become their lifeline for financial stability. Over the past seven years, the program has witnessed rapid growth, with about one in five of the nation's 6,000 hospitals having converted to CAH status. The designation has been a boon for many small rural hospitals, providing enhanced Medicare reimbursement at 101% of cost. As a result, some CAH hospitals have been able to generate solid profitability, enabling them to invest in facility upgrades, new equipment, and additional staff.

Fitch Ratings believes CAH designation enhances the ability of a small rural hospital to receive an investment grade rating. However, CAH designation alone does not necessarily result in an investment-grade rating. Currently, Fitch maintains ratings on three CAH hospitals, all of which are rated 'BBB–'. The characteristics of these three hospitals generally include a strong track record of operating profitability, solid liquidity, an ability to provide services in a low-cost setting, a stable medical and labor staff, and limited competition in the service area.

While the CAH program has been vital to the financial stability of many rural providers, these hospitals remain inherently more vulnerable to industry pressures and adverse events. Their small size magnifies any credit deficiencies and absent substantial liquidity, restrains financial flexibility. Furthermore, the growing U.S. budget deficit could either lead to reduced federal funding to the CAH program and/or significant changes to the program itself.

This report provides an overview of the CAH program, its benefits, and potential threats to the program's long-term viability, and examines the designation's relative importance to a hospital's credit rating.

Strengths of a Critical Access Hospital

- Enhanced reimbursement from Medicare.
- Revenue stability.
- Capital costs are allowable for Medicare reimbursement.
- Rural nature of the service area limits competition.

Risks of a Critical Access Hospital

- Potential cuts to funding or changes to the CAH program.
- Potential stricter eligibility requirements.
- Increased penetration from Medicare managed care health plans.
- Small size limits financial flexibility and stability.
- Construction risk due to sizable capital needs.

Background

Given limitations such as limited employment and economic bases that reflect the rural nature of their service area, many rural hospitals typically are financially fragile. Under the Balanced Budget Act of 1997, the Medicare Rural Hospital Flexibility Program (Flex Program) was created by Congress to strengthen the financial performance of rural hospitals in order to ensure access to health care. The Flex Program promoted and provided grants to each state to implement the Critical Access Hospital Program as a method for improving rural health care.

A number of legislative changes over the years have made the CAH program more viable for many hospitals. Most notably, the Medicare Modernization Act (MMA) of 2003 reduced restrictions on CAHs by allowing them to treat up to 25 rather than 15 acute patients at one time, and to operate psychiatric and rehabilitation units. The MMA also increased Medicare reimbursement to cost plus 1%. As a result, the number of CAHs has grown rapidly, increasing to 1,055 hospitals on Jan. 1, 2005 from 41 hospitals on Jan. 1, 1999 *(see chart at right),* according to the Medicare Payment Advisory Commission (MedPAC). There are now 45 states that have CAHs, with a large concentration of these hospitals located in the central U.S. Five states — Connecticut, Delaware, Maryland, New Jersey, and Rhode Island — do not participate in the Flex Program and are not eligible for the CAH program.

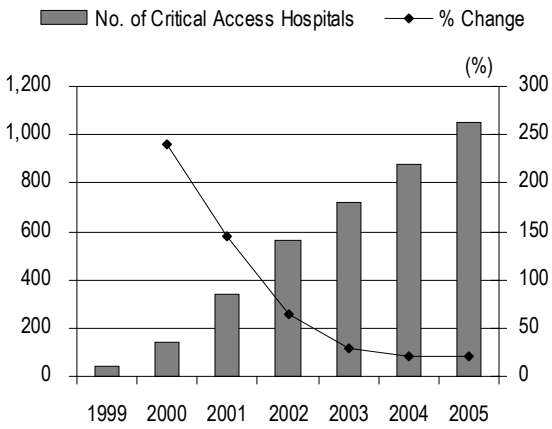
The growth of the CAH program has been further fueled by states widely utilizing their authority to designate hospitals as "necessary providers," thereby waiving the otherwise applicable CAH requirement that they be located more than 35 miles from the nearest hospital. However, the MMA eliminated the state's authority to designate a hospital a "necessary provider" effective Jan. 1, 2006. Following this date, hospitals need to meet the distance requirements to qualify for CAH designation, which may ultimately halt the future growth of the program.

Benefits of the Critical Access Hospital Program

Under the CAH program, eligible rural hospitals receive Medicare payments based on their costs plus 1%, rather than under the prospective payment system (PPS). Cost-based reimbursement under the CAH program is much more favorable than the PPS, under which hospitals are generally paid a fixed amount per patient discharge. While it is important for a hospital to effectively control costs, CAHs do not have the same incentives to manage their costs given their designation and are sheltered from annual shifts in Medicare funding. Below are the major benefits of being a CAH, which have been updated since passage of the MMA:

- Medicare payments are cost based plus 1% (101% of costs) for inpatient, outpatient, and post-acute care (swing beds) services.
- For certain states, cost-based reimbursement is also provided for Medicaid services.
- Capital improvement costs (i.e. depreciation and interest expenses) are allowable costs for determining Medicare reimbursement. For example, a CAH financing a construction project will receive additional reimbursement for associated depreciation and interest costs in proportion to Medicare services provided by the hospital.

Growth of Critical Access Hospitals
(As of Jan. 1)



Source: The Rural Hospital Flexibility Tracking Project (2003) and additional data from Center for Medicare and Medicaid Services.

Requirements for Critical Access Hospital Designation

To be designated a CAH, a rural community hospital must meet the following requirements:

- Must be located more than 35 miles on primary roads or more than 15 miles on primary roads in areas with mountainous terrain or by secondary road from another hospital.
  - — Effective Jan. 1, 2006, a state's ability to waive the distance requirements for CAH status via a state "necessary provider" designation was eliminated.
  - — Hospitals that received CAH designation with a "necessary provider" status prior to Jan. 1, 2006 will be grandfathered into the program.

- Inpatient acute care beds cannot exceed 25.
  - — Swing beds count toward the 25-bed limit and are used for post-acute care. CAHs receive enhanced reimbursement for Medicare post-acute care patients in swing beds.
  - — Rehabilitation and psychiatric units are allowed and do not count toward the 25-bed limit. These services are still paid PPS rates.
- Average length of stay has to be 96 hours (four days) or less for acute care patients.
- Must provide 24-hour emergency care services.
- Must develop agreements with an acute care hospital related to patient referral and transfer.

■ Threats to the Critical Access Hospital Program

As the U.S. budget deficit grows, the CAH program could be a potential target for reduction or elimination. According to MedPAC, Medicare payments to the CAH program will total $5 billion in 2006, approximately $1.3 billion more than if the hospitals were paid under the PPS. The Congressional Budget Office also predicts that the MMA will cost an additional $900 million to fund the program over the next 10 years. While the CAH program has grown in size, it remains a tiny fraction of total Medicare spending with some estimates of it being less than 1%. Nonetheless, Fitch believes that Medicare spending for the CAH program will continue to grow at a fast pace given the increased number of CAHs and the general trend toward increased capital spending.

Opponents argue that the CAH program provides few incentives for hospitals to control costs and to close services, ultimately resulting in above-average Medicare spending. Furthermore, some of these hospitals may be receiving enhanced Medicare reimbursement even though they may not be "critical" for access to care. According to MedPAC, the majority of CAHs are located in close proximity to other health care providers as many hospitals were able to bypass the distance requirements by receiving the "necessary provider" designation. In 2004, 43% of all CAHs were 15–25 road miles to the nearest hospital, while 16% were less than 15 miles and only 3.7% were more than 35 miles. Given the level of competition in certain markets where CAHs exist, some argue the program creates an unfair playing field for hospitals that provide similar services to a community. As a result, Fitch believes closer scrutiny over the program could grow, resulting in more restrictive eligibility requirements, which could cause some hospitals to lose their CAH designation.

The introduction of Medicare managed care to rural markets poses another challenge for CAHs. Launched in early 2006, Medicare Advantage (MA), the revamped managed care program, was created to reduce spending by using private insurers to administer Medicare benefits. As these health insurers are encouraged to move into rural markets, these plans are not required to provide cost-based reimbursement to CAHs. With little negotiating clout over managed care payors, CAHs risk being offered contracts at less favorable terms or even being excluded from a plan altogether. If passed, the Rural Health Services Preservation Act, recently introduced to Senate committees, would require MA plans to pay CAHs at no less than traditional Medicare. Fitch is currently not aware of any MA plans aggressively pushing into the markets of its rated CAHs.

■ Impact to Credit Ratings

Fitch believes CAH designation enhances the ability of a small rural hospital to receive an investment grade rating. Given their vulnerability to industry pressures and legislative changes, CAHs rated investment grade should also demonstrate a strong track record of operating profitability, solid liquidity, an ability to control costs, a stable medical and labor staff, and limited competition in the service area *(for more information, see Fitch Research on "2006 Nonprofit Hospitals and Health Care Systems Outlook," dated Jan. 12, 2006, available on Fitch's web site at www.fitchratings.com)*. Good management practices are considered important for all hospitals, and Fitch believes this also applies to CAHs rated investment grade.

CAH designation is generally considered the primary credit strength for a small rural hospital. With Medicare typically making up the largest percentage of a hospital's revenues, having the designation provides significant revenue stability and predictability. For Fitch rated CAHs, Medicare makes up 37%–41% of gross revenues, which is reflective of these types of hospitals. Revenue is further enhanced in states that reimburse CAHs at cost for Medicaid services. This enhanced reimbursement often helps offset the hospital's limited economies of scale and unfavorable and unpredictable reimbursement from other payors. As a result, CAHs have been able to grow revenues, while counterbalancing the impact of expense pressures of the industry.

While CAH designation contributes to a hospital's financial performance, Fitch believes that management practices and governance also plays an important role. A management team that is focused and proactive in

enhancing revenue cycle and supply chain management, clinical quality, and patient safety outcomes is better positioned to improving their financial footing. CAHs, like many hospitals, should continue to focus on their core competencies, divest unprofitable businesses, and select strategic investments in high-growth service lines and areas. Fitch also believes good disclosure and internal controls is a key indication of management best practices. Insufficient, unreliable, or untimely filing practices suggest management shortcomings and internal control problems. Filing cost reports on time and accurately are also important given the benefits of the CAH designation.

Good management practices and cost controls are also important given the uncertainties of the CAH program. Fitch expects investment grade CAHs to demonstrate a low-cost structure relative to their peers and a solid track record of operating profitability prior to and after receiving the designation. Solid liquidity is also important as it provides flexibility for a CAH to absorb adverse events and fluctuations in operating performance.

CAHs that face limited competition in a stable service area and have the ability to garner community support for their programs are viewed more favorably. Although CAHs are limited by the scope of services that they can provide, those that are successful in providing services that meet or exceed the quality of surrounding health care providers are positioned to do well. Fitch also believes it is beneficial for a CAH to develop agreements with its tertiary referral partner related to physician coverage and to enhance and expand clinical programs.

While it is critical for any hospital to develop strong relations with its medical and nursing staff, stability in the medical staff and continued physician recruitment is especially important for a CAH given the high concentration of admissions that usually come from a limited number of physicians. However, the rural nature and limited economic viability of many communities may significantly impede a CAH's ability to attract physicians. In addition, low nurse vacancy and turnover rates are important as agency expense can significantly impact profitability.

Capital needs for many CAHs may be extensive after years of deferral due to insufficient financial performance and limited access to the capital markets. According to Larson Allen, which performed a comparative financial analysis of more than 600 CAHs, the median average age of plant was 11.5 years in 2003, as compared with Fitch's 2003 median of 9.5 years. Recently, Fitch has witnessed a surge in CAHs entering the capital markets for the first time to fund hospital modernization and expansion projects. Given the relatively large size of the construction projects, management will need to develop effective measures to mitigate against potential delays, cost overruns, and disruptions to current services during construction. Many of the strategic investments have been focused on expanding and reconfiguring outpatient departments, since these services generally drive the revenue stream and business volumes at CAHs. In addition, many CAHs may be challenged from an information technology standpoint given their high costs and evolution to more sophisticated systems. Fitch considers it essential for CAHs to balance future capital spending without significantly impairing their financial flexibility.

■ Profiles of Fitch-Rated Critical Access Hospitals

Fitch currently maintains credit ratings on three CAHs — The Memorial Hospital (TMH), Scheurer Hospital, and Speare Memorial Hospital (SMH). Their respective profiles are summarized below and key financial metrics are shown in the table on page 5 *(for more information, refer to the hospitals' respective full rating reports, all of which are available on Fitch's web site at www.fitchratings.com)*.

The Memorial Hospital (North Conway, NH; revenue bonds rated 'BBB–' by Fitch): Since receiving CAH designation in November 2004, TMH's historical profitability levels have been further enhanced with an operating margin of 7.3% in fiscal 2005. TMH benefits from being geographically isolated, with the nearest hospitals located approximately 45 miles away, resulting in a 77.7% market share. While capital spending historically has been limited, TMH will be funding a hospital expansion and renovation project with its series 2006 bonds. Liquidity indicators are adequate with 138.6 days cash on hand and pro forma cash to debt of 72% at June 30, 2005.

Scheurer Hospital (Pigeon, MI; revenue bonds rated 'BBB–' by Fitch): Scheurer Hospital received CAH designation in July 2000, which has resulted in strong historical operating margins, averaging 6.9% over the past five fiscal years, far above the median 'BBB' category levels. While Scheurer's liquidity levels are weak due to funding its expansion and renovation projects with unrestricted cash and investments, this concern is mitigated by the hospital's strong market position. The hospital lacks significant competition in its

Key Financial Metrics for Fitch Ratings' Critical Access Hospitals

	The Memorial Hospital (NH)		Scheurer Hospital (MI)		Speare Memorial Hospital (NH)		Fitch's 'BBB'
	2004	2005*	2004	2005	2004	2005	Category Medians
Total Revenues ($000)	39,338	44,590	24,935	24,744	26,115	30,269	153,900
Days Cash on Hand	114.7	138.6	126.7	85.8	179.8	172.6	117.5
Cash to Debt (%)	497.1	72.0	78.3	56.1	17,778.8	90.1	82.1
Operating Margin (%)	1.9	7.3	7.5	3.8	0.4	3.2	1.0
Cash Flow Margin (%)	7.8	10.9	16.7	8.2	2.3	19.9	8.4
MADS Coverage Ratio (x)	2.1	4.2	2.4	1.7	1.4	2.1	2.8
MADS as % of Revenues	3.6	3.2	5.1	5.1	4.2	3.6	3.6
Debt to Capitalization (%)	8.3	43.7	36.0	34.4	0.3	34.2	47.3

*The Memorial Hospital's cash-to-debt and debt-to-capitalization ratios for 2005 factors in the series 2006 bond issuance of $21.6 million for comparative purposes. MADS – Maximum annual debt service. Note: Data reflect audited financial statements for the hospitals.

service area, maintaining greater than 90% market share. However, Scheurer operates two long-term care facilities, which historically have been unprofitable.

Speare Memorial Hospital (Plymouth, NH; revenue bonds rated 'BBB–' by Fitch): After receiving CAH designation in May 2005, SMH was able to generate stronger profitability levels in fiscal 2005, with an operating margin of 3.2%. With the nearest competitor located 25 miles away, SMH commands a leading market share of 41% in its service area. Liquidity levels are above the median 'BBB' category, with 172.6 days cash on hand and cash to debt of 90.1% at Sept. 30, 2005. SMH is currently completing an expansion and renovation of the hospital, which was funded with its series 2004 bonds.

Related Research

The following reports are available on Fitch Ratings' web site at www.fitchratings.com:

- "Health Care Rating Actions for the Six Months Ended June 30, 2006," dated July 7, 2006.
- "Quality and Patient Safety Spending in the Not-for-Profit Hospital Sector," dated May 17, 2006.
- "Rating Process for Nonprofit Health Care Credits," dated May 9, 2006.
- "2006 Nonprofit Hospitals and Health Care Systems Outlook," dated Jan. 12, 2006.
- "Sarbanes-Oxley and Not-For-Profit Hospitals: Increased Transparency and Improved Accountability," dated Aug. 9, 2005.
- "2005 Median Ratios for Nonprofit Hospitals and Health Care Systems," dated Aug. 9, 2005.